Health Workforce and Strategic Change Directorate
Shirley Rogers, Director

T: 0131-244-1826
E: shirley.rogers@gov.scot

The Scottish Government

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Dear Colleague

PROMOTING THE RETENTION OF ESTABLISHED CONSULTANTS

Summary

1. This Director's Letter contains guidance on Consultant Retention which has been formally agreed by Management Steering Group (MSG) and British Medical Association (BMA) Scotland.

Background

2. A short-life Working Group focussed on Improving the Working Lives of Consultants has been meeting to look at a number of issues. The remit of the Group is to explore the potential for joint guidance for these issues.

3. The Group comprises MSG, BMA and Scottish Government Health Workforce representation although other members may be co-opted on as necessary.

4. The Group agreed that one area for discussion was the retention of consultants throughout their career cycle, particularly those in the later stages of their career. This is within the context of protecting and enhancing the stability of NHS Scotland's consultant workforce, and effecting improvements in NHS Scotland's ability to attract, recruit, develop and retain these staff.

5. The Group has now formally agreed guidance on Promoting the Retention of Established Consultants and this is attached as an **Annex** to this letter.

Action

6. NHS Boards, Special Health Boards and NHS National Services Scotland (Common Services Agency) are asked to ensure that this letter is drawn to all interested parties.

Addresses

For action

Chief Executives, NHS Boards and Special Health Boards and NHS National Services Scotland (Common Services Agency)
Directors of Human Resources, NHS Boards and Special Health Boards and NHS National Services Scotland (Common Services Agency)

For information

Members, Management Steering Group
Members, British Medical Association, Scotland
Members, British Dental Association,Scotland

Enquires to:

Sandra Neill
Scottish Government
Health Workforce and Strategic Change Directorate
Ground Floor Rear
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Tel: 0131 244 3283

E-mail:
Sandra.neill@gov.scot

7. Employers are asked to make their own arrangements for obtaining additional copies of this Director's Letters (DL) which can be viewed at www.sehd.scot.nhs.uk.

Yours sincerely

Shirley Rogers
Director, Health Workforce and Strategic Change

ANNEX

Promoting the retention of established consultants

Introduction

- Consultants are a key part of the NHS workforce, a highly trained and very experienced resource. They represent a significant investment for both the individual consultant and the employer. They are also a limited resource and are not always readily replaced. However, the consultant role can be very demanding, both mentally and physically, particularly in specialties with high workload intensity and/or significant levels of emergency work requiring consultant-level availability 24/7.
- Changes to the NHS Pension scheme mean that a consultant's career can now potentially be 30+ years, with consultants working into their late 60s and beyond. There is now more need than ever to ensure that consultants in the later stages of their career avoid 'burnout', remain motivated to continue in their role and feel supported by the Scottish Government and their NHS Board employer to do so.
- Retention of the consultant workforce can be looked at not just in relation to the specifics of the job under discussion but also in terms of more general health and wellbeing, where wellbeing forms part of a jigsaw with engagement, culture, leadership and people management.[1]

Job planning for established (later stages of career) consultants

- There are significant variations in the extent to which both personal circumstances and job-specific factors impact on what might be considered a reasonable balance of workload activities as consultants move through their careers. There is no implication in this guidance that an older consultant cannot do as good a job as a younger consultant or vice versa. It is a simple recognition that we all age, and that there is more potential for fatigue as consultants progress to the later stages of their career.
- There may be some occasions where adjustments to working patterns need to be made for specific health-related reasons in consultation with Occupational Health. However, that can apply to consultants of any age and is not the focus of this guidance. Rather, it sets out reasonable considerations that should form part of job planning for established consultants as they progress through their career.
- Treating one group of consultants more or less favourably compared to colleagues based on age would be contrary to equalities legislation and therefore unacceptable. This does not however preclude those involved in planning, whether that is individual job planning or team service planning, from seeking to balance the needs, objectives, and strengths of individual doctors with the aims of the service.
- As stated in our previous guidance, neither team service plans nor individual clinicians' job plans can be drawn up in isolation. Service plans should be formulated in such a way that they are owned by the team who provide the service. In this context, the starting point should be empowering consultant teams to have open and honest discussions about their differing skill profiles, interests and capacities. Agreement on the allocation of specific direct clinical care (DCC) activities can be reached by building consensus within the team. The job plans of individuals may vary but each represents equal effort within the scope of the contract.
- For example, one issue that arises frequently is the impact of shift or out-of-hours work on older consultants. Evidence suggests that for people who are further on in their

[1] *"Growing the Health and wellbeing agenda: from first steps to full potential", CIPD January 2016*

career, decreased quality of sleep, with shorter deep stage 3 and 4 levels, makes it much more difficult to repay a sleep debt. It may be that some members of the consultant team are keen to stop covering on-call overnight, but would be happy to increase their daytime weekend commitment instead. In contrast, younger consultants may welcome the additional exposure to the emergency care commitment at that stage in their careers.

- There may be a number of ways to change job plans in a mutually beneficial way. It often involves agreeing 'equivalency' for given DCC activities in job planning terms. Hence an increased daytime commitment covering weekend on call activities may be agreed to replace the overnight commitment in a given specialty. There is no formula that can be applied but mutual agreement between rota participants is key.
- We need to recognise that one size does not fit all. Some solutions are potentially much easier in bigger departments, while regional approaches may work for smaller teams. In some areas there may be a role for technology-driven solutions although this must be developed with the support and involvement of the clinicians involved.

Job satisfaction

- Maintaining a sense of job satisfaction is a crucial retention tool for the consultant workforce. Small incremental deteriorations in this aspect of consultant working lives are key factors in discouraging retention.
- A common theme amongst consultants progressing towards the end of their career concerns their ability to develop roles that progress and build on their early careers. For example, the systems they find themselves working within do not always facilitate expression of leadership, research and innovation, education and training skills.
- While there is always the need to take account of the needs of the service, some capacity to consider the balance of DCC with other activities (supporting professional activities, additional responsibilities and external duties) or even more formal time out (e.g. sabbaticals) is crucial.
- Recognition and appreciation for decades of service in an intensive, pressurised work environment may include facilitating time for research or educational effort that has been frustrated in the earlier part of a career by clinical service requirements.
- We would encourage all consultants to complete iMatter, the NHS Scotland tool designed to help improve staff experience and, if necessary, complete the relevant Health and Safety Executive stress at work assessment.
- Boards should actively support their medical advisory structures (which should include consultants who have accrued experience and are at later stages of their careers) and thereby generate a sense of responsiveness to their consultant body.
- The evaluation of the implications of service transformation must include the impact on the current workforce. In this context, consultants who have long-established patterns of working and who may not see a role for themselves within a very different structure, need to be considered. For example, if a service is to be moved centrally, albeit for good reasons, it may be that those consultants left behind in the feeder hospital no longer perceive sufficient critical mass to remain. The negative impact of losing these key individuals should not be ignored or lost in the strategic decisions that need to be taken. Including such consultants in the early planning/discussions of such a transformation, in line with the Staff Governance Standard[2], will usually reduce the risk of this negative impact considerably.

[2] Staff Governance Standard; a framework for NHS Scotland Organisations and Employees, 4th Edition, Crown Copyright 2012

- ‘Efficiencies’ that (potentially) negatively impact on the working lives of consultants need to be sense-checked with those in post. For example, whilst pooled administrative support may deliver a faster letter throughput, it will remove the key source of support and patient-centredness from a given service. Discussion and two-way communication to mitigate any negative impact in advance of such a change is key.
- Positive steps to improve work life balance, such as access to IT from home should also be given active consideration

Succession planning

- The retirement of a senior doctor can sometimes trigger an unsustainable workload crisis, particularly in remote and rural services, or if the service is already stretched. This can potentially create a vicious circle as the remaining consultants start to consider their own retirement options. This can be a particular problem in smaller departments and hard to recruit specialties.
- Careful succession planning can help prevent this. Each service area or department should regularly consider the age demographics and plans of incumbent consultants to minimise the risk of unsustainable workload pressures from retirement. Consultants approaching retirement can help the rest of their colleagues by, if possible, giving informal notice of their long-term plans well in advance of their formal notice period. Employers can help to avoid service pressures by moving quickly to fill any identified vacancies as soon as possible. This may be achieved by appointing to the same post, by service redesign, or by locum cover on an interim basis. A locum appointment would only be made until a substantive appointment is possible.
- Proleptic appointments should be actively considered where appropriate and always when service sustainability is not possible with the remaining staff. For example, a small remote and rural hospital with 3 consultants on an on-call rota should have very specific advanced planning in place for covering sickness (or other long term) absence and for retirement of incumbents. There may be opportunities for some Consultants to go to less than full-time to allow a partial overlap period with a new Consultant taking up a particular sub-specialty interest on a proleptic basis. In contrast, larger departments will find that there is much more capacity to flex the roles of the existing workforce in the face of retirement whilst plans are made to replace retiring colleagues.

Continuing contribution beyond retirement

- Some consultants are keen to continue working for the NHS after taking their NHS pension benefits. The number wishing to pursue this route may be increasing following recent changes to pension tax allowances, which are prompting some consultants to retire earlier and take a reduced pension to avoid breaching the lifetime allowance. They potentially form a significant element of the consultant workforce, and in some cases may be vital to maintaining a service in the short to medium term.
- In order to receive their NHS pension, a consultant must formally retire from their substantive consultant post. As re-appointment on a substantive basis would involve going through the full Advisory Appointments Committee process, the usual route is to return as a locum consultant.
- Formal retirement can be a very traumatic time for someone who may have worked in the NHS for 40+ years, and the potential move from a position of security to the uncertainty of locum post can be disconcerting. Additionally, the liabilities of required fees and memberships falls solely on the retiree who faces this uncertainty, adding to the

disincentive to offer continuing service. It is therefore important that there is full discussion between consultant and the NHS Board at an early stage, and certainly long before the point of retirement, to clarify expectations, identify flexibilities that could be employed to the advantage of both the doctor and the employing Board and to generally ensure that the any locum arrangements will work to the satisfaction of both parties.

- Employers should offer appraisal and revalidation opportunities free of charge for retirees from NHS Scotland substantive posts for as long as the retiree is available for NHS work in their NHS Board.
- Employers should offer continuity of administration (including PVG certification, OHS, mandatory training requirements etc).
- For those returning on a longer than 6-month basis, study leave should be made available.

- Discussions should consider the nature of the work the consultant would be undertaking in their new role, and the extent to which their job plan would change, e.g. any reduction in hours, participation or otherwise in the on-call rota, the on-going balance between clinical and non-clinical activity etc. The expected duration of their locum employment will also be a key consideration, e.g. will they just be providing cover until a new consultant is appointed or is a longer-term open-ended role envisaged up to a maximum of one year. It is important not to neglect other issues which may appear less significant, but can impact significantly on a consultant's willingness to continue, e.g. arrangements for appraisal and revalidation, on-going access to secretarial support, and any other pre-existing arrangements that support that consultant role. Much of the above reflects good management practice which should be applied to returning consultants in the same way that it is applied to the existing consultant workforce. There should be clarity of expectation both for the consultant and employer not just in terms of areas such as the nature of work to be undertaken, the job plan, and duration of employment, as outlined above, but also the management and review arrangements which will be associated with any post.